Strategy Research Project

DECREASING NON-DEPLOYABLES: A CRITICAL TASK

BY

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USAWC STRATEGY RESEARCH PROJECT

DECREASING NON-DEPLOYABLES: A CRITICAL TASK

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ABSTRACT

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The Army has experienced a significant number of non-deployables over the last nine years. The largest category is medical non-deployables. In an effort to reduce the number of non-deployables, the Army should review policies, procedures, and regulations to manage non-deployables while sustaining personnel readiness. Without changes to legislation and culture at the senior military and civilian leadership level, an opportunity to decrease non-deployables may be missed. This strategic research paper defines non-deployables and reviews the Army's current goals and solutions. It describes the friction between taking care of Soldiers and managing our non-deployable numbers and reviews recent Army initiatives to reduce non-deployables. It concludes with recommendations to increase available deployable personnel.

DECREASING NON-DEPLOYABLES: A CRITICAL TASK

> Prevailing in today's wars and preventing future conflicts depends on the Department's ability to create and sustain an all-volunteer force…Multiple long deployments are taking a serious toll on our people…we must tend to the health of the All-Volunteer Force, for it constitutes the foundation of our national defense.
>
> —QDR, 2010

The Army lives by the motto "I WILL NEVER LEAVE A FALLEN COMRADE," but not just on the battlefield. This motto is also used in an Executive Summary given by General (Ret) Frederick Franks, Jr. in his Final Task Force Recommendations to Better Fulfill the Army's Duty in Medical Evaluation Boards and Physical Evaluation Boards. This Task Force informs leaders that the Army will do what is right for wounded, ill, and injured Soldiers. The motto embellishes the Army's desire to faithfully protect Soldiers undergoing medical rehabilitation and care for their well-being. Over the last nine years, the Army has done a tremendous job providing quality care, despite some road bumps along the way. Our Soldiers have fought long and hard to protect U.S. national interests. Many have died or been injured to preserve our freedom. As a result, a large number of Soldiers are now medically non-deployable.

This strategic research paper defines non-deployables and reviews the Army's current goals and solutions to this problem. It describes the friction between taking care of Soldiers and managing our non-deployable numbers. It reviews current Army initiatives for decreasing non-deployables. It concludes with recommendations to increase available deployable personnel.

Non-deployable is a personnel category used by the Department of Defense to classify whether a Soldier is fit to perform his or her duty during a unit's deployment.

There are numerous categories of non-deployable personnel covered in AR 614-30. However, the largest current category of non-deployable personnel is designated as medical non-deployables. These Soldiers have been found to be psychologically or physically incapable of deployment. Sub-categories under medical readiness include pregnancy, the-25 day rule, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), absence of Deoxyribonucleic Acid (DNA) Collection Record, drug abuse, Post Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI). Some of these conditions are considered minor issues, but others are designated as major issues.

Consider the following minor issues: Pregnant Soldiers are non-deployable until they give birth. New mothers are non-deployable for four months after the birth of their children. Also, "Soldiers identified within the first 25 days of enlistment as having a pre-existing medical condition that renders the individual non-deployable may be released from active duty immediately."[1] Soldiers who test positive for HIV/AIDS over 24 months prior to deployment are non-deployable and removed from overseas operations immediately. Soldiers missing a DNA-collection record can be mobilized, but are considered non-deployable. Immediately after the Soldier's DNA is on file, he or she will be considered fully deployable. Soldiers determined to be drug dependent are non-deployable. Those who test positive for drug use, but are not considered dependent on these drugs, are deployable.

Major medical conditions include PTSD and mTBI. PTSD is a common anxiety disorder that develops after exposure to a terrifying event or ordeal. Soldiers considered to have a mild case of PTSD will be treated locally. Severe cases will be

recommended for a Medical Evaluation Board (MEB) for disposition. "mTBI is defined as an injury to the brain resulting from an external force (acceleration or deceleration mechanism) or event which causes an alteration in mental status."[2] Soldiers identified with mTBI are recommended for a MEB or Physical Evaluation Board depending upon the severity of the case.

Non-deployables play a significant role in Brigade Combat Teams' (BCTs) readiness. BCTs are the Army's primary deploying unit. In 2008, BCTs averaged 12% medical non-deployables at their Latest Arrival Date (LAD), the last date when a unit, a resupply shipment, or replacement personnel can arrive and complete unloading at the port of debarkation and support the operations. In 2009, the number of medical non-deployables remained the same at 12% at LAD, but this increased to 14.47% in 2010. Although these numbers have varied from two to four percent over the last three years, the revision of Army Regulation 220-1 (December 2009), Non-Deployable Category, will significantly impact the readiness status of BCTs. Previously minor categories such as permanent profiles, temporary profiles, dental readiness, and immunization were deleted from AR 220-1. These medical conditions are now considered deployable categories unless a physician deems a Soldier unfit for deployment. In most cases, these issues can be resolved prior to deployment, so these Soldiers are determined to be Fully Mission Capable (FMC).

As of 14 Oct 2010, the active Army experienced a 14% non-deployable rate of approximately 6,946 of 52,000 assigned Soldiers within 16 deployed BCTs. Among these, 861 were non-deployable pending administrative discharge (Soldiers who terminate their enlisted contract or are pending disciplinary separation); 717 were

scheduled for ETS/retirement; 203 were non-deployable for parenthood issues (parenthood is defined as a military mother of a new born or one parent of a military couple adopting a child); 421 were non-deployable for insufficient dwell time (dwell time is defined as the time a Soldier spends at home station between combat deployments, operational deployments [non-combat], or dependent-restricted tours); and 2,935 were non-deployed for medical reasons."[3] Always a challenge, medical non-deployability is becoming a greater problem. Non-deployables increased from "10% in 2007 to 14%"[4] in 2010. Medical non-deployables (mostly due to combat injuries) amounted to 33% in 2007, 28% in 2008, 38% in 2009, and 32% as of September 2010. On average, medical non-deployables accounted for 4.6% (FY10 YTD) of a BCT's assigned strength in October 2010. This includes non-deployable Soldiers undergoing an MOS Medical Review Board (MMRB), Medical Evaluation Board (MEB), Physical Evaluation Board (PEB), Temporary Medical Conditions, and incomplete Soldier Readiness Process (SRP). "These medical non-deployables account for 32% of a BCT non-deployer population, same percentage as Fiscal Year (FY) 2007."[5]

Non-deployable Soldiers impact a BCT's training for combat operations. A BCT commander's primary concern is Soldier readiness. Without these personnel, the BCT cannot perform its war-fighting mission. Without a full complement of Soldiers, commanders are unable to conduct their Mission Rehearsal Exercise (MRE) effectively. The MRE is conducted before deployment. MREs enable Soldiers and their leaders to work out details of how their mission will be performed after deployment to a theater. If Soldiers are unavailable for MREs, some individual and collective tasks are not performed, degrading mission readiness. When crews are not fully manned, combat

power is reduced. The BCT S1 is responsible for coordinating directly with the U.S. Army Human Resources Command (USAHRC) to manage personnel shortfalls.

In the Army Forces Generation (ARFORGEN) model, the BCT S1 is required to provide a monthly (LAD-180) by-name list of non-deployables by category to the Army G1 Personnel Contingency Cell (PCC). At LAD-90, BCT S1s are required to submit their non-deployable information bi-monthly. The Army G1 consolidates this information and provides it to other Army G1 supporting agencies and HRC (both Enlisted Personnel Management Division (EPMD) and Officer Personnel Management Division (OPMD)). These categories are reviewed by the Career Managers and Readiness Branch. The Readiness Division, EPMD uses the (HQDA Summary of Brigade Combat Teams) report to analyze the data reported by BCT S1s. The Readiness Division then determines if the unit's non-deployable numbers are decreasing or increasing. HRC also uses these numbers to track data accuracy in the Enlisted Distribution and Assignment System (EDAS).

"The Enlisted Distribution and Assignment System (EDAS) is a real time, interactive, automated system which supports the management of the enlisted force."[6] Using EDAS, career managers can process assignments and execute deletions and deferments. They can also validate, modify, or add requisitions (defined as slots that HRC creates against an authorized position). EDAS is also managed at the BCT S1 level, so the BCT Strength Manager can track unit strengths and assignments. EDAS is used by career managers (usually Sergeants First Class and civilians) and readiness managers (civilians designated to manage specific BCTs) at HRC to track non-deployables. Soldiers in EDAS are coded by Medical Readiness Classification (MRCs).

MRC Class 1 Soldiers are available and meet all medical readiness requirements. Those identified as Class 2 are available with deficiencies correctable within 72 hours. Soldiers coded as Class 3A/3B are considered non-available. Class 3 Soldiers have deficiencies expected to take more than 72 hours to correct. Soldiers classified as "3A are medically deployable within 30 days. Class 3A includes deficiencies that would be resourced for correction for alerted Reserve Component Soldiers. Deficiencies may include Dental Class 3s. Class 3B coded Soldiers have medical deficiencies or requirements that will take more than 30 days to correct."[7] Class 3B includes pregnancies, limited duty profiles, deployment limiting conditions, temporary profiles exceeding 30 days, and permanent P3/P4 profiles pending Medical Evaluation Boards or Physical Evaluation Boards. MRC Class 4 deficiencies are Soldiers with missing and incomplete current Physical Health Assessment (PHA) and dental screening. These Soldiers are considered available.

The use of MRC codes allows HRC to assign some non-deployables to appropriate units. These units are usually in RESET, not operational units, or not on the "Patch Chart" to deploy. A Patch Chart identifies all units designated to deploy. Operational units in RESET (defined as "a set of actions to replace personnel and restore equipment to a level of combat capability commensurate with a unit's future mission),"[8] and not on the Patch chart are minimally manned. These minimally manned units have a large number of 3A/Bs who will hopefully recover from their medical condition in time for a deployment. Assigning non-deployables to non-deploying units requires coordination among various MOS career managers. This system is designed to prevent any unit from containing more than 10% non-deployables. Filling a unit such

as a BCT with 10% non-deployables could be devastating if the Army G3 inserts that BCT on the Patch Chart or if the BCT's LAD shifts significantly to the left. Therefore, it is essential that career managers track MRC codes and manage assignments accordingly.

The Medical Readiness Classification (MRC) tracking system assists HRC in maintaining personnel requirements. Tracking MRC 3A/3B coded Soldiers enables medical and HRC to monitor and manage non-deployable Soldiers. "In December 2009, HRC began using MRC Codes as screening criteria for assigning Soldiers to deploying units."[9] MRC data is obtained manually by pulling information from Medical Protection System (MEDPROS). MEDPROS is used to track all immunizations, medical readiness, and deployability data for all Active and Reserve components. This interoperable tool is linked to Net-centric Army Unit Status Report (NetUSR) for reporting non-deployables. NetUSR is a "Web-enabled readiness data input tool that imports data from authoritative sources to support required readiness assessments."[10] NetUSR also links to the HRC Electronic Military Personnel Office (eMILPO), which provides unit users, personnel managers, and commanders with visibility of military personnel services. These tools have facilitated career manager's assignments of MRC-coded Soldiers to appropriate units.

The Army's ceiling for all non-deployables per BCT is ten percent. The Army Manning Guidance (AMG) for Fiscal Year (2011) directs "that HRC will man deploying BCTs between 105%-110% enlisted strength prior to latest arrival date (LAD) in order to achieve minimum deployed strength of 95%."[11] The Army's manning strategy must support ARFORGEN requirements to ensure a steady stream of trained and ready units

to Combatant Commanders. Although HRC is meeting this goal, it is nonetheless severely challenged to provide the right skill sets as it adheres to these stringent requirements.

Another tool used by the Army to handle non-deployables is the Personnel Policy Guidance (PPG), which was released on 17 September 2002. Its purpose was to consolidate theater and Army personnel policies during contingency operations into a single document. Based on the vast number of personnel changes during the Global War on Terrorism, the PPG is considered a living document, not simply a published regulation. "This decision allows for continuous updates based on approved policy guidance and revisions to All Army Activities (ALARACT) and military personnel (MILPER) messages, Department of Defense (DoD) instructions, and Army Regulations."[12]

The PPG addresses Soldier Readiness Processing (SRP) by requiring commanders to identify all non-deployable Soldiers within 60 days of a unit's deployment or the date when a Soldier departs on a Temporary Change of Station (TCS) order. Each installation has their own policy for scheduling SRPs. Some BCTs schedule SRPs periodically, some immediately after their MRE when they receive 100% of their assigned strength. Some commanders relentlessly pursue their non-deployables, while others wait until LAD before they inquire about replacements. Most commanders recognize the earlier they inform HRC of their non-deployable shortfalls, the quicker they receive backfills.

SRP is the starting point of Soldier readiness; it should be the main effort in identifying non-deployables. Used along with the installation readiness checks, Soldier

Readiness Checks (SRC) and Reverse-SRC ("a five station rotational event to conduct chaplain services, medical and dental screening, risk reduction and medical briefings immediately after redeployment"),[13] it becomes a useful tool. Most importantly, assigning NCOs to process Soldiers through these stations provides first-line supervisors with valuable information. In some cases, minor issues can be resolved through leadership intervention. For example, "something as simple as having contact lenses on during SRC will prohibit the Soldier from receiving the Small Pox immunization."[14] Under these circumstances, the medical section will allow the Soldier to come back later without completing this part of the processing. In some cases, Soldiers fail to return, thereby receiving a not cleared during the SRC. This is why an NCO's presence is crucial; it allows a leader to not only monitor the Soldier, but decreases the BCTs' non-deployable stats.

Per ALARACT 284/2009, medical guidance is essential for advising commanders on issues that may decrease their personnel capabilities and strength. Most importantly, medical guidance focuses on potential problems that could affect the health of a Soldier, that could identify any physical limitations, and that could alleviate potential life- threatening situations. In some cases, these ailments or illnesses could affect the unit's mission. Commanders must be responsible for their Soldiers' well-being and for unit readiness. Commanders must also monitor the readiness of their Soldiers and address issues as they arise. "All Soldier readiness issues should be identified by the unit, installation, and HRC well in advance of formal SRP checks in order to minimize the number of non-deployables."[15] Commanders , coordinating with their BCT S1s, must

complete the formal pre-deployment SRP 60 days prior to deployment to effectively manage non-deployables.

Managing non-deployables has become such an arduous task that many Command Sergeant Majors (CSMs) have assumed the duties of managing them. They vigilantly track and expedite out-processing to ensure unit readiness. CSMs perform this task by maintaining a daily status report of all non-deployables. They coordinate with unit Sergeant Majors and First Sergeants to ensure Soldiers make their appointments to resolve their MRC status or to be transitioned out of the Army as needed (depending upon the status of non-deployability). Separating non-deployable Soldiers are expedited through the transition center and out-processed. Soldiers that are separating from the Army must have a scheduled final-out appointment. "Final out appointments will be made 10 days prior to a Soldier's leave date (DA31)."[16] Soldiers without an appointment will not be seen. CSMs and first line supervisors are staying abreast of these appointments to ensure that separating non-deployable Soldiers who should be discharged or are ready for discharge are immediately out-processed. This expedited action assists HRC's ability to fill these vacancies in a timely manner. Coordination of these actions with HRC will better assist the command in its efforts to fill key developmental positions.

The Army understands that non-deployables degrade personnel readiness. But Army leaders are challenged by the friction between taking care of Soldiers and managing non-deployable numbers. Taking care of Soldiers means making sure they are prepared for the unit's mission. In the case of non-deployables, taking care of Soldiers require either reintegrating them back into the fighting force, or transferring

them to non-deployable units, or separating them from the Army. Exercising the appropriate option entails getting them to appointments for rehabilitation, enabling them to fulfill training requirements, or simply assisting their movement to the transition center for separation. Managing non-deployable Soldiers involves a host of actions. Effective management of non-deployable Soldiers enhances combat personnel strength.

The friction between taking care of Soldiers and managing non-deployable numbers surfaces when BCT S1s try to balance their combat personnel strength with overwhelming non-deployable numbers. When BCTs average 14% non-deployables, their first call should be to their HRC account manager, who has the responsibility for coordinating with various career managers to determine the availability of personnel. This is accomplished in a one-on-one discussion with the branch or simply by pulling up the installation's account to determine if excess Soldiers are available on that installation. The Army's mission is to win our nations' wars. This means that the primary mission is combat readiness. But the difficult task is to reach a balance of managing strength with maintaining a healthy and capable force. If a BCT is unable to conduct its MRE or have the appropriate personnel fill at critical points in the ARFORGEN cycle, then HRC and the installation have failed the BCT commander. All HRC managers and leaders are responsible for maintaining personnel readiness.

Research reveals that during RESET, NCOs consider taking care of non-deployable Soldiers an appropriate responsibility due to the limited amount of scheduled training. After RESET, NCOs should then be responsible for accountability, accomplishing assigned missions, and processing Medical Evaluation Boards (MEBs) or mental health issues. "The challenge faced in the Rear Detachment is that most non-

deployables account for 70% of a BCT's roster."[17] This includes Soldiers with temporary profiles, Wounded-in-Action (WIA) Soldiers returning for treatment, and Soldiers with P3/P4 profiles. Usually these Soldiers are being processed through a MOS Medical Review Board or MEB or PEB.

Although the Army is challenged to restore balance and set conditions for non-deployables, it has undertaken impressive initiatives to mitigate the influx of non-deployables. But a challenging process requiring revision is the Military Occupational Skill (MOS) Medical Retention Board (MMRB). The MMRB is a monthly administrative screening board to determine Soldiers' physical ability to satisfactorily perform Primary MOS/Branch duties worldwide in a field environment. Board recommendations include retaining in MOS, reclassifying to another MOS, or referring to the MEB and PEB. MMRBs have contributed to our non-deployable problem and will continue to do so if we maintain this World War II process. Soldiers undergoing an MMRB are sometimes bound into the process for as long as six months. The majority of time is allocated for improvement or reevaluation. These cases are taking too long, and the Army is working to improve the process. Soldiers can be directly referred to an MEB if they do not meet the medical retention standards of Army Regulation (AR) 40-15, Standards of Medical Fitness. Members of the MMRB include the Division Surgeon, a BCT commander, a Sergeant Major, and the Medical Treatment Facility (MTF) representative. Despite MMRB issues, commanders must be held accountable in maintaining a 10% non-deployable rate. This means taking a hard look at how much time it takes for out-processing medical non-deployables.

The current "MMRB process has numerous problems as currently organized, the least of which is that physicians, Physical Evaluation Board Liaison Officers (PEBLOs), and profiling physicians don't understand how it operates."[18] One of the problems with the current MMRB process is the Army's need to retain Soldiers with critical skills. Soldiers desiring to stay in the Army who do not meet retention standards do not currently qualify for MMRB reclassification. Therefore, little is done to assist Soldiers requiring reclassification prior to the MEB. This action holds the Soldier in a non-deployable status for longer than necessary, which then hampers the commander's ability to train in specific skill sets and significantly affects his unit's wartime capability.

As a result of the MMRB shortfall, the Deputy Chief of Staff G-1 created the Military Occupational Specialty (MOS) Administrative Retention Review (MAR 2) Pilot Continuation Guidance to give Commanders a tool for processing profiles for Soldiers. It will review Soldiers' permanent medical limitations and initiate a mandatory administrative review to determine whether a Soldier meets his primary or secondary MOS standard. On 2 August 2010, the Army G-1 approved the MAR2 to replace the MMRB at Fort Drum, Fort Leonard Wood, Fort Bliss, and Fort Jackson, and in four National Guard states, (New York, Maryland, Pennsylvania, and Illinois), and two USAR RSCs (81st and 88th). "The MMRB historically evaluated Soldiers with numerical designator of 3 or 4 in one of the profile serial factors recorded on DA Form 3349 (Physical Profile) based on their physical ability to perform duties in a worldwide field austere environment."[19]

The MAR2 process will determine a Soldier's ability to perform his/her duties within their MOS or recommend reclassification into another specialty. If a Soldier fails

to meet their MOS requirement, a referral to the Physical Disability Evaluation System (PDES-- a medical system used to determine the fitness and applicable disability benefits of Soldiers with duty-related impairments) will determine the disposition of the Soldier. Each component's senior Human Resource Career Manager at HRC will review the Commander's recommendation, the Soldier's input and medical evaluation to make a decision in conjunction with the Army's needs. Consider the results of this pilot program:

MAR2:

- Cost savings of 20.3 million dollars per year
- Acceptable by all stakeholders and promotes Soldier readiness
- 100% accountable in Medical Protection System (MEDPROS) and component administrative management systems

The MAR2 process begins when the Soldier receives a P3/P4 profile. A copy of the profile is given to the commander's representative. The unit Career Counselor counsels the Soldier, obtains relevant documents (profile, CDR statement, Soldier statement), and forwards this information to the Commander and the Senior HRC proponent. HRC reviews the document for accuracy and makes a determination. Two questions are asked – Is the Soldier qualified for MOS? If yes, Soldier is approved to return to duty, If not qualified, proponent is asked if he or she will waive disqualification. Is the Soldier eligible for reclassification? If yes, then the Soldier is scheduled for new MOS training.[20] If the Soldier declines a reclassification, the senior human resource authority will refer the Soldier to the Medical Evaluation Board (MEB). Documentation is distributed to the Commander and MEDPROS representatives. HRC will update

personnel databases to ensure appropriate tracking and follow on assignments. The MAR2 Pilot program is scheduled to last until 31 Mar 2011.

The active Army has 17,710 permanent P3/P4 profiles. Among these, 3,240 are fit for duty (18%). The Army intends to either return the remaining 14,470 Soldiers to duty or separate them. The MAR2 process will allow Commanders and S1 staff to automatically track the process through MEDPROS to determine personnel readiness. This will allow the Commander to better project his combat readiness for deployment, and preparation for training. During the four-month pilot, 76 MAR2 packets were received and 57 were adjudicated. Six were recommended for PDES, 17 returned to duty and 34 were reclassified. The average time from initiation of MAR2 to Senior Human Resources adjudication was 29 days, compared to 31 days under the MMRB – a minimum gain for processing. The average processing time from profile complete to SR HR decision was 56 days, versus 68 days under the MMRB system. In the MAR2 pilot program, 98% of Soldiers had all appropriate documents, which were 100% accurate. By comparison, MMRB soldiers had only 53% of appropriate documents, and only 69% of these were complete. Further, 78% of Soldiers' MMRB documents were inaccurate.

Although the MAR2 results are impressive, the Army has been slow to implement the program. BCT retention counselors must reduce the time to initiate the MAR2 by submitting cases to HRC in less than 14 days, compared to the current 28 days. This will allow HRC to manage this program expeditiously and thereby enable BCTs to meet their required level of fill prior to LAD. Additionally, commanders and retention counselors should share information with the Commanding General during monthly Unit

Status Report updates to increase senior level visibility. As the Army continues to implement the program, maintaining BCTs' deployable personnel strength and decreasing non-deployable numbers should be a priority.

The Medical Evaluation Board (MEB), and the Physical Evaluation Board (PEB) also contribute to this issue. A MEB validates whether Soldiers meet the Army's medical retention standards. Injured Soldiers returning from Iraq or Afghanistan by-pass the MMRB. These Soldiers are immediately processed through the system for rapid evaluation. "If the treating physician believes that combat injured Soldiers are unable to perform full military duty or are unlikely to be able to do so within a reasonable period of time (normally 12 months), the Soldier is referred to a MEB at the Medical Treatment Facility (MTF) where treatment is being provided."[21]

The PEB makes a determination regarding retention, separation or retirement. It also determines the percentage of the Soldier's disability compensation using Department of Defense Directives (DoDD) and Instructions (DoDI), Army Regulations, and current Army policy for rating disabilities. If a Soldier receive a rating of 30% or greater, he or she is either placed on the Temporary Disability Retirement List (TDRL) or permanently retired for disability. Soldiers who get a rating of 20% or less will receive disability severance pay. The PEB also determines whether the medical impairment precludes the performance of the primary military Occupational Skill (PMOS). Under Title 10, U.S.C., chapter 61, the Secretaries of the Military Departments have the authority to retire or separate Soldiers when they are unfit to perform their military duties because of physical disability. Most MEB/PEB actions occur when a Soldier voluntarily goes to a Medical Treatment Facility (MTF). Commanders are authorized to refer a

Soldier when they believe the Soldier is unable to perform his duties for medical reasons. "This examination may cause conduct of a MEB, which will be forwarded to the PEB when it finds that the member's medical condition falls below medical retention standards."[22]

Soldiers with a physical or mental health problems who are unable to deploy for more than 12 months will undergo a MEB. Only the MTF can initiate a medical board. Medical boards are conducted by physicians (not involved in the care of the Soldier) who review the clinical case file and make a determination based upon published medical standards. Currently, Soldiers identified for MEB or PEB are retained in the BCT for up to six to eight months. However, some BCTs are moving Soldiers who are expected to need six or more months of care and who need complex medical management to a Warrior Transition Unit (WTU) – units created to provide critical support to wounded Soldiers. Although WTUs are designed to care for wounded Soldiers, Soldiers with non-combat related disorders – such as coronary diseases, schizophrenic and bipolar disorder, acute anxiety, kidney disease, leukemia, and chronic back pain-- are entering the WTUs. As of July 2010, "38% of Soldiers assigned to the WTU were non-combat related medical issues. Squad leaders and others who work inside the WTU say they are filling up with the undeserving."[23] Instead of separating these Soldiers, Commanders are referring them to the WTU. Many of these Soldiers are in no rush to leave.

BCTs that move Soldiers pending MEB to the WTU are effectively manning their units. Getting these Soldiers off their rosters ensures that HRC provides replacements if they are available. Many of these Soldiers possess critical MOSs that affect crew

manning and combat capabilities. These are the MOSs BCT S1s should request from HRC. Finally, "if the MEB determines that the member has a medical condition which is incompatible with continued military service, they refer the case to a Physical Evaluation Board (PEB)."[24]

The PEB is also a formal board convened to determine the fitness and disability of a Soldier. PEBs may recommend one of the following:

- Return Soldier to duty (with or without assignment limitations or medical re-training)
- Place the member on the temporary disabled / retired list (TDRL)
- Separate the member from active duty or medically retire the member

The PEB determines Soldiers' fitness based on whether the medical condition precludes the Soldier from reasonably performing the duties of his or her office, grade, rank, or rating. Declaring the Soldier unfit to perform these duties or considering the Soldier otherwise unfit is not solely based on geographic location, but whether or not the Soldier is deployable. Deployability is considered in determining fitness. "Recommendations are forwarded to a central medical board and can be appealed by the member, who is permitted to have legal counsel at these hearings."[25]

Another Army initiative to improve medical readiness is the Installation Medical Management Center (IMMC). This pilot program at Fort Stewart and Fort Knox monitors the status of MEB/PEB Soldiers. The strategic objectives of the pilot program are to expedite recovery time after injury or illness, decrease the amount of time during which Soldiers cannot perform their duties, and reduce the number of Soldiers maintained in a medical- not- ready (MNR) status. Additional objectives include

decreasing the timeline for determining when a Soldier should be released from the medical channel, and facilitating a return to duty in a gradual capacity to contribute to full mission readiness. The mission of the IMMC is to provide coordination between the MTF and other installation units to facilitate mission command and medical management. The overall intent is to decrease Soldier recovery time, to reduce the time a Soldier is unable to perform his or her duties, and to reduce the time for a medical retention decision.

This program will cost the Army 2.2 million dollars. The problem is that MEB/PEB Soldiers will continue to reside in the BCT. Any pilot program designed to more rapidly rehabilitate the Soldier must also consider the placement of the Soldier. Any Soldier considered non-deployable for medical reasons reduces the BCT's combat readiness. If the BCT is the primary deploying force, then HRC, medical command, and other stakeholders must provide solutions for placing non-deployables in garrison commands (non-BCTs). Pilot programs are designed to support certain lines of operations and to produce a desired endstate. The two pilot programs discussed in this SRP will impact non-deployable status, but can they significantly decrease non-deployables? The answer will be revealed in months to come. In the meantime, other initiatives must be considered as the Army develops a comprehensive approach to decreasing non-deployables.

Recommendations to decrease non-deployables include a variety of cultural changes on how the Army perceives its care of Soldiers, how the Army mitigates problems, and how the Army responds to the projected end strength drawdown of 49,000 Soldiers.

Taking care of Soldiers is a sensitive issue. Soldier care involves families, the public, and DoD civilians. These parties believe the Army's duty is to take care of every Soldier, regardless of the problem. The Army Values and Warrior Ethos affirm this enormous responsibility. However, leaders must acknowledge that not all Soldiers are able to carry the torch or persist until the job is done. Even so, leaders must persist doing what is right while making the hard decisions about taking care of Soldiers and balancing the force. Soldiers will always be the Army's most valuable resource. But when that resource degrades capability then it is the leader's job to realign, readjust, or simply change the priority.

For example, 3RD Brigade Combat Team, 10th Mountain Division, Fort Drum, N.Y. created a Brigade Resiliency Team (BRT). This team is comprised of the BCT/Battalion (BN) Commanders and Command Sergeants Major (CSM), BCT Behavior Doctor, the BCT Surgeon, and the Warrior Training Unit Case managers. Once a month, the BRT meets at the BCT level and reviews the packets of Soldiers identified as "high risk" by their chain of command. The BRT recommends to the BCT Commander the best course of action (COA) for each Soldier and the Army: retention in the unit, transfer to the WTU, or separation from the Army. This is what taking care of Soldiers is about. It's about commanders engaging in dialogue to reflect on the best COA to resolve challenging issues affecting personnel readiness. This is a forum that could easily provide the BCT Retention NCO a forum for reviewing the status of Soldiers undergoing a MAR2. The BRT could also expand to include a representative from the IMMC (once the pilot program is operational at all installations) to address MEB concerns for every

Soldier. A comprehensive meeting once a month could significantly reduce non-deployables and create stability within the command.

The PPG should recommend using a BRT to determine appropriate options for non-deployable Soldiers. It should also change the time Forces Command (FORSCOM) units are required to conduct Soldier Readiness Processing (SRP). The current policy of 60 days does not provide HRC ample time to provide a backfill. The current assignment policy allows HRC to fill a position within 120 days. To be consistent, SRPs should be conducted 120-180 days from LAD to support assignment requirements. Non-deployable data is provided from the BCT to the Army G1 PCC, but it has usually changed six months out. Accurate early identification of non-deployables could create a win-win situation for the Soldier and the command. Our current operational environment demands creative change.

In the past few years, the Army mitigated its personnel shortfalls by a congressionally authorized temporary increase in end-strength by 22,000 Soldiers, which increased the Army's personnel strength to 569,000. This increase compensated for the high number of non-deployables and Soldiers assigned to the Trainees, Transients, Holdees and Students (TTHS) account. This account identifies Soldiers not assigned to units. Although the increase temporarily assisted in the over-manning of deploying units, it also masked the problem of non-deployables to meet mission requirements. Non-deployables were pushed to the side as commanders trained their units that HRC had filled at 105%. The increase masked an influx of non-deployables who still reside in BCTs even with the end of hostilities in Iraq. The challenge now is to rebalance the force by getting the right Soldiers in key positions. This means reforming

the Army's personnel policy supporting the two up and one down rule. Soldiers considered qualified to serve in positions, but not yet school trained, should be trained. Those in positions not performing in the next grade should be evaluated or moved to another position. Getting NCOs and leaders trained for professional growth should contribute to the Chief of Staff's rebalancing goals. Failure to pursue this objective will continue to force the Army to mitigate the problem while it has an opportunity to rebalance.

Another way to decrease non-deployables is to initiate legislation to change how the Army manages its end-strength. Currently, Soldiers are in a Modified Table of Organization and Equipment (MTOE), Table of Distribution and Allowances (TDA) or TTHS. Secretary Gates has noted, "Assigning non-deployable Soldiers to major accounts in the institutional force is in violation of the Secretary of Defense's directive to reduce the institutional force."[26] The Army should be allowed to create a separate account for MEB/PEB non-deployables; while they are being processed they should not be included in the Army's end-strength.

The Army should also consider executing a mass reclassification effort to mitigate shortfalls. The Army Vice Chief of Staff and HRC should also share monthly results of the Army Strategic Readiness Update (ASRU) with the field. The ASRU provides a personnel readiness update to senior leaders within the Pentagon. It indicates several areas requiring assistance and reports how the Army will maintain a force strength, especially in BCTs. This data should be distributed across the force to keep the field Army abreast of vital information. Sharing information and sustaining strategic communications is essential to the Army's well-being.

On 17 January 2011, the Army Times posted an article claiming "the Army will cut 49,000 Soldiers and billions of dollars in coming years."[27] The Army's end-strength will decrease from 569,400 to 547,400 active component Soldiers by 2013. "The Army expects to see another cut of 13,500 in 2015 and another 13,500 cut in 2016."[28] These significant cuts are based on projected requirements and budget constraints. This is also an opportunity to reduce the active Army's non-deployable numbers. The Medical Command should coordinate with installation Commanders and HRC via MEDPROS and EDAS to identify Soldiers unable to perform their duty. These Soldiers should be reviewed by the BCT commanders and separated accordingly if they cannot be reclassified. If the Army uses this opportunity to cut 10 percent of the non-deployables, rebalancing the force by 2013 will be an obtainable goal.

In conclusion, the Army G1, Medical Command, and Human Resources Command have done a tremendous job of meeting our non-deployable challenge. However, their efforts fall short of accomplishing the task at hand. The Vice Chief of Staff has repeatedly identified non-deployability as a priority, but no hard line approach has been promulgated to decrease non-deployable numbers. Commanders at all levels must understand the culture we face and realign their perspectives accordingly. One remedy is to fill the BCT only to 105% including additional plus-ups. Commanders would then deploy at no less than 95%, no exceptions. When commanders are provided no more than 105%, they are compelled to decrease their non-deployable populations earlier in the ARFORGEN cycle. When SRPs are conducted only 60 days prior to LAD, HRC does not have the time to provide replacements. So HRC must scramble for replacements or assign them after the unit deploys. Last-minute fills are

unacceptable: They have not trained with the unit. They represent a reactive solution to a problem that should be addressed proactively.

The pilot programs implemented within the Army G1 will solve some of our problems, but they offer only slow-moving opportunities. DoD must provide the funding and personnel resources to man the IMMC for such programs to be effective. Like anything in the military, budget is critical for performing any task. So leaders must be innovative in combining their efforts to produce measurable results. Patience and resilience are fundamental tools required for this challenge, and leaders must issue appropriate regulations to decrease non-deployables. As leaders and Human Resource Managers, our goal is to support the objectives specified by the leaders in our hierarchical structure. Accordingly, this responsibility includes taking care of our most valuable resource – Soldiers. If we fail to get this right, we will not have a second opportunity. We must treat our Soldiers with respect and dignity. A U.S. Army War College faculty instructor observed that if the only tool you have is a hammer, then every problem becomes a nail – referring to our overreliance on the military as an instrument of national power. As Army leaders, we have a variety of tools. Using them to fit the situation will enable us to expedite the handling of non-deployables and their families. Anything less than taking care of Soldiers and balancing the mission is criminal. We must turn our culture upside down to reverse 20th Century thinking. We must commit to making the hard decisions in separating Soldiers we know can never deploy or be able to serve effectively.

As we decrease Army end-strength, we must also maintain integrity within the ranks. We do this by maintaining a ready and capable force. We do this by leveraging

efficiencies to reduce BCT medical non-deployable numbers by 50%. If we remain in Afghanistan until 2014, then we assume the risk of more casualties. Let's put an end to the increasing problem of medical non-deployables by creating appropriate internal processes and procedures, by changing our policies and legislation, by reforming our reclassification program, by expediting separations as needed, and by using the Army's projected end strength reduction to retain deployable Soldiers instead of those who cannot meet deployability standards.

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